

Kelsey (C. B.)

---

# ABSCESS AROUND THE RECTUM.

*A Lecture at the Clinic for Diseases of the Rectum, at  
the New York Post-Graduate Hospital.*

BY

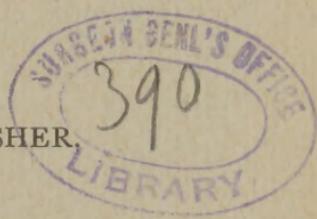
CHARLES B. KELSEY, M.D.

---

REPRINTED FROM THE THERAPEUTIC GAZETTE, JANUARY 16, 1893.

---

DETROIT, MICH. :  
GEORGE S. DAVIS, PUBLISHER,  
1893.





## ABSCESS AROUND THE RECTUM.

---

**G**ENTLEMEN:—I am glad to be able to show you to-day a case of great practical interest to you all, and one of a kind which you must all be ready to treat at a moment's warning, and often without any opportunity for consultation. The hemorrhoids and the fistulæ you may temporize with; the excisions and colotomies you may send to somebody else; but when called to one of these you must act at once or get somebody else to act for you.

The patient under ether is, as you see, a strong young laborer, in excellent physical condition; on the left buttock and perineum you observe a brawny swelling, which it requires no skill to say contains pus. In fact, after the perineal region has been cleansed and made aseptic, you see me plunge a long, straight bistoury well up into the ischio-rectal fossa and evacuate pus through the puncture thus made. You all notice the foul character and faecal odor of the same. This does not prove that the abscess communicates with the gut, for pus near the rectum will often have this foul faecal odor from proximity, without actual perforation.

This, then, is our case,—a simple abscess in the left ischio-rectal fossa, into which I have put



a bistoury, and from which the pus is steadily escaping in a small stream through an incision just as long as is the breadth of the knife-blade that made it. But let nobody imagine this case has been operated upon, for we have not begun to operate. I have let out a little pus to show you that pus was there and to teach a lesson ; that is all. We will operate later.

The case just as it is now before you reminds me so forcibly of one that I operated upon only yesterday in private practice that I must compare the two to impress the lesson I wish to convey upon you. A young woman on her wedding-journey begins to suffer acutely from pain in the region of the rectum. She bears it as long as she can,—about three days,—and then consults a doctor, who fails to make a diagnosis. After a week of suffering she reaches home, is examined by the family physician, and an abscess the size of a small egg is discovered in the ischio-rectal fossa. Exactly such an incision is made as you have seen me make here, but in that case not for diagnosis, but to cure. Four weeks later I was asked to see the case. The suffering had not been relieved, the patient had been confined to her room and the lounge, and for the last week the pain had been almost unbearable, particularly when the bowels were moved. On examination the puncture made on the right side of the rectum was still discharging freely, and on the opposite side there was just such a painful brawny swelling as you see here. The finger in the bowel showed also that this new abscess was bulging into the lumen of the gut. I say new abscess, but it was not new. It was the same one which had been punctured a month before on the opposite side,

and had gone steadily on destroying the parts ever since.

The treatment was radical. First, the old puncture was enlarged till my finger could enter. Next, the newer collection of pus in the other ischio-rectal fossa was incised and the finger of the other hand passed into it. The two fingers came together in the median line between the vagina and rectum, and when the incision was finished it reached from a point well below and to the right of the bowel, straight around over the perineum to a corresponding point in the left fossa. Nor was this all, for on the left side the pus was just about to open into the gut; no tissue was left except unsupported mucous membrane, and a director was forced through this and both sphincters cut. The gentleman asks, "What became of the perineum?" There was no perineum except the skin. What had once been the perineum was part of an abscess cavity. If you ask what will be the effect of the disease and the transversal incision across the perineum for its cure, it will be weeks before I can tell you. Of course the common insertion of the sphincter vaginæ, sphincter ani, and transversus perinei was cut. I do not think there will be incontinence of faeces, but what will be the final effect upon the vagina and internal organs of this loss of support time alone can tell.

After the incision all septa of broken-down tissue were removed, and the entire abscess cavity being brought to the light, it was dressed with bichloride gauze.

We will do the same to this man, and let him be taken away. I pass a blunt-pointed bistoury into the puncture already made, and

enlarge it upward and downward for fully two inches. With my finger I find that this one also has started for the opposite fossa, and also in front across the perineum, instead of behind the anus, and I follow the pus with a transverse incision, but only just up to the median line, which is as far as the pus has had time to burrow.

Now comes the point at which you must use your judgment and when experience is of great value. In the other case I told you that after doing what I have just done here I found the pus separated from the rectum only by mucous membrane, and that it was necessary to divide both sphincters. Here the sphincters will not be divided. The other case, when it was first punctured, was exactly like this, and the same sort of treatment would have cured it. But when I saw it it was practically a horseshoe fistula,—an abscess surrounding the rectum in the form of a horseshoe, with the points turned downward, and with an external opening made by the physician on one side of the gut, and an internal opening made by the disease on the other. I must try and make this very plain to you, because the whole treatment depends upon it. I say that in the young lady's case there was an internal opening, and yet in describing the operation I said the abscess cavity was separated from the gut by mucous membrane, which I tore through with a director, and then cut the sphincters, laying the abscess cavity open into the bowel. The latter was the exact condition, and yet, as in spite of laying open the abscess so freely, this thin partition of mucous membrane was sure to break down later and form a fistula, I treated the case as one of fistula al-

ready formed. Had this not been done, the patient would in the future have required a second operation for fistula.

In this case, because we have operated earlier, there is still a good deal of healthy tissue between the abscess and the rectum,—about half an inch. There is no fistula, and there will be none. There is, therefore, no indication for interfering with the sphincters or the rectum.

The rule may be stated in a more general way. When you cut into an abscess around the rectum, and find that one wall of the abscess cavity is made up in part of the rectum itself,—in other words, that the pus is working towards the cavity of the bowel, and has already begun to press upon it,—you may be certain that perforation of the gut will occur in spite of free skin incisions, that a fistula will thus be formed, and render necessary at some time the usual division of the sphincters. It is, therefore, better to complete the destruction which the abscess has so nearly accomplished, open the latter into the bowel, and do the usual operation for fistula in addition to opening up the abscess cavity.

When, on the other hand, as in this case, you find that you have seen and operated upon the abscess in time, and that the pus has not yet reached the gut, but that there is still sufficient tissue on the rectal side for healing to occur without perforation, you will treat the abscess exactly as though it were in any other part of the body. It is not a fistula,—you have operated early enough to prevent its ever being a fistula,—therefore it has no more relation to the rectum than it has to the urethra, and it

would be as sensible to open it into the one as into the other.

Some experience will be necessary to enable you to decide this point in the treatment. Half an inch of tissue between the two cavities is a good practical rule.

And now comes the main point in this whole lecture. It is, in these cases, to always operate without delay. They are not like abscesses elsewhere, where you can wait till the pus finds its own escape. I never in my own practice allow a night to intervene between the diagnosis and the incision in one of these cases, for a few hours may make all the difference between an abscess and a fistula; between continence and incontinence of faeces for life; between a couple of weeks' and many months' confinement. Nor do I wait for pus to form in these cases. They almost never undergo resolution, and it is useless to poultice and waste time. When you see a hard, inflammatory swelling in the perineum or buttock, cut into it at once, and cut deeply and freely. The pus will follow in a day or two, if it is not already formed. In this way only will you prevent great destruction of the soft parts, and perhaps irreparable injury to rectum or bladder. I have shown you how the incision should be made so that no pockets are left. Lay the entire cavity open, break down all partitions and sloughing tissue, irrigate with bichloride, and dress with bichloride or iodoform gauze.

The after-dressing is simple but important. The gauze put in at the time of the operation should be left till it has become softened by discharge and can be removed without pain, say on the second or third day. Often this is

the only dressing that need be used during the case, the after-treatment consisting simply in passing the finger along the wound every second or third day to make sure it is healing from the bottom, and not falling together and uniting at the sides, leaving a cavity behind. If there should be any indication for dressings, use them. If the granulations are feeble, stimulate them; if exuberant, cauterize them; but don't stuff the wound with gauze merely because there is a wound. It is a wound that nature will often take care of much better than we can, if we keep it clean with simple water and let it alone.

The complications to be met with in these cases are many. I saw one not long since where the diagnosis was only to be made by rectal examination, there being no hardness or redness of the skin. The pus was away up at the apex of the ischio-rectal fossa, and was pressing upon the rectum at that level, and had also closed the urethra, so that the man's symptoms were very misleading. His physician had made a diagnosis of "inflammation of the rectum" because of the pain in the rectum, but there was no pain around the anus or perineum. The man was also suffering from a distended bladder, with overflow. On examination a hard, inflammatory mass the size of a large orange was found projecting into the gut from the left side, about three inches above the anus.

The important question in such a case is where to evacuate the pus, through the rectum or on the buttock; and here, as in the case you have seen, the decision rested upon the amount of tissue intervening between the abscess cavity and the rectum. Had there been only the rec-

tal wall, I should have incised it, let the pus escape freely by the anus, irrigated and drained the cavity, and left the case to nature, merely keeping the incision into the gut open by the occasional introduction of the finger. The abscess might in this way have healed kindly, or pus might have eventually worked its way to the skin, forming a complete fistula. But judging, from the impression made upon the finger, that there was still a considerable barrier between the abscess and the gut, I determined to open it from the buttock. A long bistoury was therefore passed parallel with the bowel straight up for three inches, till pus appeared by the side of the blade. The incision was then enlarged till it admitted two fingers into the abscess cavity, which was broken up and cleaned out in the usual way. The subsequent treatment consisted only in keeping this incision open by the daily passage of the finger through it up to the abscess. The latter closed up promptly before the deep incision was permitted to close at all, and the patient made a good recovery, without impairment of the function of the parts.

In this way only can the formation of extensive fistulae, the cure of which may necessitate deep incisions, and future incontinence be avoided. Many patients have been rendered unhappy for life by the mistake of some practitioner in thinking that an abscess around the rectum was the same as an abscess anywhere else, and could either be left to discharge itself, or would do well if the pus were evacuated by a small incision.



JANUARY 18, 1893.

WHOLE SERIES, VOL. XVII.

No. 1.

THIRD SERIES, VOL. IX.

—THE—  
**Therapeutic Gazette**  
A MONTHLY JOURNAL  
—OF—  
General, Special, and Physiological Therapeutics.

GENERAL THERAPEUTICS,

H. A. HARE, M.D.,

Professor of Therapeutics in the Jefferson Medical College.

OPHTHALMIC AND AURAL THERAPEUTICS,

G. E. DE SCHWEINITZ, M.D.,

Clinical Professor of Ophthalmology in the  
Jefferson Medical College.

SURGICAL AND GENITO-URINARY THERAPEUTICS,

EDWARD MARTIN, M.D.,

Clinical Professor of Genito-Urinary Diseases, University of  
Pennsylvania.

EDITORIAL OFFICE, 222 South Fifteenth St., Philadelphia, U.S.A.



All Subscriptions and communications relating to the business management should be addressed to the Publisher,

GEORGE S. DAVID, DETROIT, MICH., U.S.A.,

OR

114 Filbert Street, Philadelphia, Pa.

Published on the Fifteenth Day of Every Month.

SUBSCRIPTION PRICE, TWO DOLLARS A YEAR.

Agents for Great Britain: Mr. H. K. LEWIS, Medical Publisher and Bookseller, 190 Gower Street, London, W. C.

Entered at the Post-Office at Philadelphia, Pa., as second class mail matter.

Circumstant, 1893, by GEORGE S. DAVID.

PRINTED BY J. B. LIPPINCOTT COMPANY, PHILADELPHIA.